Chapter 18. Methadone maintenance spreads

At the 1968 methadone maintenance conference, reports were heard from programs in Chicago and Philadelphia as well as New York. By the 1969 conference, at least 23 cities were known to have methadone maintenance programs--- some of them several programs. Reports were again heard from Chicago, Philadelphia, and New York, along with Minneapolis, St. Louis, Baltimore, New Haven, New Orleans, Miami, and Vancouver. At the 1970 conference, Washington, D.C., San Francisco, and other cities also reported. The discussion that follows is based in part on these reports, and in part on visits paid to methadone maintenance programs in New Haven, Baltimore, New Orleans, San Francisco, Portland (Oregon), Vancouver, Chicago, and London in the course of research for this Consumers Union Report.

Several programs outside New York started when a courageous local physician heard about the Dole-Nyswander program and decided to give it a try on his own personal responsibility. Dr. Emmett P. Davis, a Baltimore physician with a private practice primarily in pediatrics, started the first Baltimore program in this way; his program is now under the aegis of a private agency, Man Alive, Inc., set up for the purpose. Several other Baltimore programs are now in operation, one administered by Johns Hopkins.

In Minneapolis, too, the first methadone program was launched as a private undertaking by an internist in private practice, Dr. Robert A. Maslansky. By the time he had 39 patients on the program, however, he found he had too little time left for his regular practice. Accordingly, he stopped further private enrollments, and launched a second program under the auspices of Mount Sinai Hospital in Minneapolis. A third program was later established in that city.

In New Orleans it was a municipal judge, Andrew Bucaro, who spearheaded methadone maintenance. Judge Bucaro, like many others on the bench, grew weary and angry at the steady parade of addicts passing before him--- few of them for the first or even the second time. When he heard about methadone maintenance, he began phoning physicians in a search for one who would try it in New Orleans. After eight consecutive rebuffs, he reached Dr. James T. Nix, who already had one patient on methadone in his private
The two Nix clinics now have more than 160 New Orleans patients coming in for methadone daily, and six other methadone maintenance clinics (including one for women run by a Catholic nun) are now operating. By the fall of 1970 the eight New Orleans clinics were treating about 1,200 patients.

The pioneer methadone-dispensing physicians, as might be expected, faced some community opposition; they were, after all, dispensing an addicting drug to addicts. Several programs reported repeated visits from federal, state, and local narcotics agents, and a few were closed down; but nobody was criminally prosecuted. Dr. Nix in New Orleans notified his county medical society on March 7, 1968, that he was going to open a methadone maintenance clinic—- and received the following ultimatum in reply six days later:

It was the unanimous opinion of the Board of Directors of this Society that it would be wise, particularly from an ethical standpoint, for you to disband this clinic.

Please let me hear from you by March 23, 1968, as to your intention in this matter. i.e., do you plan on continuing the clinic or has it been disbanded?

Dr. Nix bravely continued his clinic, and no further action was taken by the county medical society.

Dr. Maslansky in Minneapolis reported several difficulties. The three programs there, he noted, "have not gone without some official criticism. ... Our legal preoccupations in each clinic have been formidable from the beginning." The clinics were warned by law-enforcement officers that the Harrison Narcotic Act (Section 151-392) "provides criminal action against ... those who would issue a prescription to an addict for the purposes of providing the 'user with narcotics sufficient to keep him comfortable..." The sponsors of the programs refused to be intimidated, however, and no prosecution under Section 151-392 was initiated.

Dr. Maslansky was also called to account before the Minnesota Board of Medical Examiners. His license to practice medicine was clearly at stake. "I lost 20 pounds, that's all I can say," he told the 1969 methadone conference. At the beginning of his hearing Dr. Maslansky felt that the board members "thought they were dealing with either somebody perniciously involved ... for the simple [purpose] of making money out of it, or, even worse, [with] a benighted do-gooder." After Dr. Maslansky had addressed the board for ten or fifteen minutes, however, he recalled, "I could see that they had melted somewhat, and after the full presentation, in fact, the Board came around full circle and simply asked me how they could be of some help to me. In fact, since then they have been immeasurably helpful in getting the entire thing off the ground." Similar changes in attitude, once methadone maintenance has been adequately explained, have been reported in other cities.

Everywhere the new programs were faced with expressions of concern that doses of methadone might be diverted from the maintenance program to the black market. Some
methadone has been diverted, and some will no doubt be diverted in the future, despite intensive efforts to prevent such diversion. But the diversion problem must be viewed in proper scale. The American black market is currently supplying addicts with an estimated 250 to 375 million heroin "fixes" per year. The diversion of even tens of thousands of doses of methadone to that market would thus add barely a drop to the ocean of illegal narcotics already available.

"It is true occasionally," Dr. Trussell remarked at the 1969 methadone conference, "that one of our 1,300 patients will give one of his friends one of his bottles of methadone in orange juice. I do not worry about this because the same fellow could go 300 yards in almost any direction and get all the heroin he wanted." 13

Some of the programs outside New York offer, along with the methadone, routine health care plus a wide range of individual psychiatric services, group psychotherapy, social work, employment counseling, legal aid, and rehabilitation services, much on the Dole-Nyswander pattern. In all probability these auxiliary services are useful and effective, and raise a clinic's success rate. What amazes visitors to less comprehensive programs, however, are the relatively good results achieved merely with methadone plus the limited kind of counseling that may occur when an addict comes in for his dose. Drs. Dole and Nyswander themselves have recently set up a small-scale experimental unit in which methadone is dispensed with a minimum of auxiliary services; when the results from this unit are later compared with the results in full-service units serving comparable groups of addicts, more light will be thrown on the value of and need for full auxiliary services.

Since the cost of the methadone itself is trivial---ten cents per day---the cost of a program depends primarily on the range of such auxiliary services. Dr. Dole estimated in 1970 that a budget for comprehensive treatment, including not only methadone but all of the auxiliary services, costs $1,500 the first year, $1,000 the second year, and $500 a year thereafter. This, of course, is only a fraction of what it costs to imprison an addict and an even smaller fraction of what society loses through each addict who maintains his addiction through crime.

The programs that lack broad auxiliary services are cheaper. The Man Alive program in Baltimore and the Nix Clinic program in New Orleans, for example, originally operated on $500 or $600 per patient per year, including first-year patients. (In Baltimore, and elsewhere, volunteers helped keep down the cost of staffing.) Both the New Orleans and Baltimore programs, moreover, were very nearly self-supporting; the patients themselves paid $10 or $11 a week for the service. In Maryland, methadone maintenance programs are now chargeable to Medicaid, like other accepted forms of medical care, and Man Alive, Inc., now receives a substantial state grant for its operations. 14

Ultimately it should prove safe and feasible to make methadone available on prescription, like insulin or any other maintenance medicine, at a daily cost of ten cents---$36.50 per year---a price that the user himself can readily pay.
In New Orleans, the methadone maintenance program for women addicts administered by Sister David serves imprisoned addicts. Each day the police paddy wagon brings the women prisoners to the clinic and takes them back again. On the day of their release from prison, they are already fully stabilized methadone maintenance patients, freed of their craving for heroin and blockaded against heroin effects.

Most programs take both wives and husbands, and a substantial portion of the addicts on some programs are couples.

Many of the successful methadone maintenance programs across the country rely heavily on addicts themselves for two major roles. One is the counseling of patients newly admitted to the program. An addict fresh off the street isn't likely to believe much of what a doctor or nurse tells him but he gets the message promptly from another addict. Second, the patients fully rehabilitated on the program are indispensable in keeping a sharp eye open for potential abuses. Rehabilitated addicts have an enormous stake in the long-run success of the program, and will protect it in every way possible. An addict newly admitted often looks for "angles"--- he can easily fool the doctors, but he can hardly fool his fellow addicts who have long since learned all the tricks. Dr. Jerome H. Jaffe commented on this at the 1969 methadone maintenance conference:

At least in Chicago, if somebody comes in and takes something, we know exactly who he is and where he hangs out. He's going to have 300 enemies in our program who have very few compunctions about letting him know that he's jeopardizing the entire program, and their way of demonstrating their displeasure with him may be much more severe than anything the courts can do. 15

Dr. Herbert D. Kleber, director of the New Haven program, commented similarly:

The patients feel a great sense of loyalty to the program and feel very strongly that each individual in a program is responsible not only for himself but for every other individual in the program, and therefore if someone messes up, that is a threat not only to himself---the possibility that he can go back to jail--- but to everyone else in the program. 16

Not all programs achieve this high morale. The impression gained on visits to methadone clinics was that the ones which fail to make use of patients in their day-to-day operation have lower patient morale and are less successful.

Relations between the methadone maintenance programs and the police are usually tense in the beginning; police officials understandably wonder what the world is coming to when doctors dispense addicting narcotics to addicts, free of charge or at low cost. But the police, too, change their minds when they see the results of methadone maintenance. Dr. William A. Bloom of the Tulane University School of Medicine methadone maintenance program cites an example.

We invited the police to refer to us the worst addicts they knew of, just to see what happens, and the result of this, we think, has been [our] single best selling point, because
the police and the addicts on the street know each other--- they work the same hours . . . .

The police soon learned that the majority of [patients on methadone] no longer have new tracks [needle marks] and can prove a legal source of employment and they know we've got a good product. 

Among the most significant of the addiction treatment programs currently under way outside New York is one sponsored by the Illinois Department of Mental Health. Like most other states, Illinois until a few years ago spent little or nothing on addicts, beyond the costs of arresting, convicting, and imprisoning them. Unlike California and New York State, it thus had no vested interests in existing programs, and no vast annual expenditures to maintain ineffective programs. In 1965, Illinois established a Narcotic Advisory Council, and in 1967 that council set up a wide range of addiction services, all under a common administration but in competition with one another. The director until 1971 was Dr. Jerome H. Jaffe of the University of Chicago--- Pritzker School of Medicine.

Among the Illinois programs were a methadone maintenance program with auxiliary rehabilitation services, a methadone maintenance program without auxiliary services, a detoxification program, a program using other drugs (such as cyclazocine), a drug-free program using group psychotherapy and other psychological approaches, and a "therapeutic community" program modeled on Synanon and Daytop. Addicts were assigned at random to these programs. A further control was provided by addicts on the waiting list who received no services whatever. Thus each type of program could demonstrate its worth, or lack of worth, on patients all drawn from the same pool.

In addition to replicating the Dole-Nyswander methadone results in New York City, the Illinois program has pioneered a number of ingenious variations on the Dole-Nyswander theme. One of these variations consisted in taking types of patients specifically excluded from the New York program--- such as criminal offenders assigned to the program by the courts as an alternative to imprisonment. Some of these court cases were put on methadone; others received group therapy and other rehabilitation procedures without methadone. Dr. Jaffe summed up the preliminary results at the October 1969 methadone maintenance conference: "We can only say that the [court referrals] assigned to methadone ... do as well as people who volunteer.... They do . . . considerably better than [court referrals] who are randomly assigned to non-methadone programs." 

While the Illinois findings are still preliminary, they almost all point to methadone maintenance as the keystone in any comprehensive program for narcotics addicts. Dr. Jaffe was asked about this at the October 1969 meeting:

Dr. Paul H. Blachly (Portland, Oregon): I would like to ask Dr. Jaffe ... given a fixed amount of money, what would be the best way to [use it] most effectively?"

Dr. Jaffe: "I think our data indicates unequivocally ... if I had dollars to spread around in my town ... we would be expanding our methadone program without any question."
Dr. Blachly: "How much of that will go into rehabilitation if you have to make the choice between more drug and more rehabilitation?"

Dr. Jaffe: "Every time I'm presented with an absolute choice, more will go into the drug. Fortunately I think our community is rational and mature enough to recognize that every dollar they invest in the program as a whole is going to save them money in terms of the cost to the community and the rehabilitation of people who are now able to function. So that for the time being our expansion is limited only by our capacity to train and orient and to work out effective working relationships with other programs. When money becomes a problem I will tell you now that it will go into the provision of adequate amounts of drug rather than elaborate rehabilitation programs."

Dr. Jaffe was also asked what proportion of all addicts were likely to accept a methadone program.

"At present," he replied, "we have had applications from 1,500, approximately, of the known ... 6,000 heroin users, in Chicago; and [about] 80 percent . . . prefer some form of methadone program. So that those people seem to have an uncanny notion of what is good for them. . . ." Those dragooned into treatment by court edict as well as those who volunteered preferred the methadone program and did well on it. Only 3 percent of the addicts expressed a preference for a "therapeutic community" experience of the Synanon or Daytop type.

The Tulane Medical School methadone maintenance program in New Orleans takes addicts over eighteen years of age who have been addicted to narcotics for at least six months. Some of the other programs throughout the country set a minimum age of twenty-one for methadone maintenance, and a minimum period of addiction of two, three, or even four years. Dr. Blachly of Portland, and others, however, question the wisdom of these limitations. The prognosis for the teen-age addict is so dismal, they say, and the likelihood of continuing addiction so high, that they favor making methadone available even to quite young addicts, and even after a relatively brief period of addiction. There have been suggestions, however, that newly addicted teen-age addicts who are still on their "heroin honeymoon" and have not yet experienced the woes of long-term addiction may do less well on methadone.

The Dole-Nyswander program has had patients as young as nineteen and-a-half. In addition, a few younger teenagers, some as young as sixteen, are being maintained on methadone experimentally; all were addicted to heroin at least two years before being accepted for methadone maintenance. Withholding methadone maintenance because of age "is a real dilemma," Dr. Dole told the 1969 methadone conference. "We have had parents and ministers come to us and ... say, 'Does this boy have to go to jail and suffer two more years of addiction which he already is in? He's been in jail.' So I think that the answer as of today is that if a person is unmistakably an addict with an uncontrollable daily heroin habit and already into and on his way into more trouble for two years, then he is sufficiently into it to justify methadone treatment."
Age is one of two major methadone issues on which there is as yet no consensus. The other concerns the length of time an addict must remain on methadone.

Dr. Dole in New York City has had the broadest experience in "weaning" patients from methadone. In a number of cases, he reports, patients who have been on his program with complete success for periods as long as five years have asked to be "tapered off" so that they can live drug-free thereafter. These patients have long since severed their ties with the underworld. They have renounced a life of crime. They may have steady jobs, good homes, warm relations with spouse and children. They no longer have a craving. Why should they continue the nuisance of going to a clinic and swallowing an orange drink spiked with methadone?

By the end of 1969, Dr. Dole had had experience with 562 patients who were weaned from methadone. The pharmacological results were consistent in all cases. "It is easy to reduce the methadone dose down to about 50 milligrams per day. Drug hunger is still controlled.... If you then continue to reduce the dose to somewhere between 20 and 40 milligrams per day, the person will begin to experience a return of the old heroin hunger, not hunger for methadone but [for] heroin." This return of the postaddiction syndrome (anxiety, depression, and craving) is parallel to that of the addict who serves five years drug-free in a prison-yet heads for the nearest black market soon after his release.

The renewed craving for heroin, Dr. Dole concedes, is not uniform; some feel it more acutely than others--- but they all feel it, including "the people who have been thoroughly rehabilitated."

This finding is of great theoretical as well as practical importance. Heroin relapse after prolonged abstinence is generally attributed, as we have seen, to social or psychological factors. The addict, it is said, returns to his old addicted buddies and therefore relapses. He sees others "shooting" and therefore relapses. He loses his job or wife or girl friend and therefore relapses. Dr. Dole's observation is that the addict's craving (and drug-seeking behavior) returns even though he has cut himself off from his old neighborhood and his old associations, and has built a whole new satisfying life free of heroin. The craving, he is therefore convinced, is a biochemical phenomenon rather than a psychological urge. "The thought that a social rehabilitation might cure a metabolic disease I think can be well disproven by the experience we have had to date."

Dr. Dole does not deny that a few patients now on methadone might hereafter live completely abstinent. A few people, after all, can permanently kick the heroin habit without methadone at all. "But this, I can say quite flatly, will be a minority," Dr. Dole concludes. Most heroin addicts on methadone, like most diabetics on insulin or other antidiabetes drugs, he believes, will have to continue to take the drug for the rest of their lives or until something even better than methadone is discovered. Those who do give up methadone--- including those fully rehabilitated experience a return of the postaddiction syndrome followed by drug seeking behavior and relapse in a high proportion of cases. Then, somewhat sheepishly, many of them come back to methadone maintenance again.
Dr. Jaffe, on the basis of the more limited Illinois experience, is not quite so sure about the inability of methadone patients to live drug-free. Some Illinois patients ask to be weaned from methadone after only a few months. A substantial proportion of those who are weaned, Dr. Jaffe concedes, relapse to heroin as in New York. But a few have made it thus far and the Illinois research program includes several efforts to develop ways to help them make it.

Sometimes there are excellent reasons for not weaning a patient from methadone. A striking example is cited by Dr. Gerald E. Davidson of the Harvard Medical School, director of the Chestnut Hill Clinic, a psychiatric clinic with a large methadone maintenance program, and medical director of Elan, a drug-free therapeutic community.

"One of my patients," Dr. Davidson reports, "is a boy from the most self-consciously 'best' suburb of Boston. He comes from a broken family, dropped out of high school, and had been in difficulty for some time. He was carried on methadone for a while, and I said to him one day: Phil, how about quitting?" He said: 'Look, doc, I spent two years in a mental hospital diagnosed as a schizophrenic, and then I found dope--- first heroin and then methadone. Since I've been on dope I finished high school and got a scholarship to art school. I'm only a junior but I'm teaching courses and I've got faculty status and my work has been winning prizes all over the place. I'll be damned if I quit now.'"

Addicts, like other patients, Dr. Davidson comments, "frequently know what is good for them. They frequently know better than doctors and other wise, helpful, well-intentioned people........ He continues, "I have repeatedly seen many young people--- and adults, too--- who, on comparatively small doses of methadone, tell me they feel normal, are able to work, are able to live with their families and to carry on a normal life. Otherwise they are what we call borderline ... personalities, who cannot tolerate any kind of frustration, who cannot really maintain a job, who tend to act out with some kind of violence whether verbal, physical or in some other way--- whenever they're frustrated, and who, in general, are quite unsuccessful in life. Many of these people do extremely well on methadone."

Not all of the other methadone maintenance programs enjoy the DoleNyswander success rates, and a few are clearly failures. In no program, however, is a high failure rate due to the methadone per se. Methadone elsewhere, as in the Dole-Nyswander program, is pharmacologically effective: it relieves the addict of his craving for heroin.

In some cases, low success rates * are due to the attitudes of the staffs of methadone maintenance programs. One program, for example, lost more than half its patients in the first twenty-four weeks. Investigation revealed that the staff was nagging and hounding the patients and in general treating them as if they were criminals. The patients, not unnaturally, walked out. When the staff is all white and middle-class, and the patients are not, there is greater likelihood that friction between staff and patients will lower the success rate. Using methadone patients themselves to help operate the program raises morale noticeably.
* That is, low as compared with the Dole-Nyswander program. No methadone maintenance program approaches the tragic failure rates of the nonmethadone programs described in Chapter 10.

Senator Harold Hughes of Iowa pointed out one way in which a program can be sabotaged.

We had a very small methadone withdrawal program running [in Des Moines]. There had been nothing prior to this at all but apparently the police infiltrated the withdrawal program and put men in the withdrawal room as patients in order to gain confidential information from the addicts. This blew the program clear out of the water, and now there is not a heroin addict that would come for treatment to anyone in the city. The addicts are back on the streets having to steal $100, $200, $300 a day to maintain their heroin habit.

We all support the police, and we all support everything we can do to cut back the importation of heroin and opium, getting the suppliers and distributors. We can have a health program trying to get people off the streets but as long as we use them as an infiltrative organism of the vice squad they will be unsuccessful.

A clear light is thrown on the problems of methadone maintenance failures by a follow-up study of 95 patients who left one of the eight New Orleans methadone maintenance programs. This study, by Richard G. Adams and William C. Capel in collaboration with Drs. William A. Bloom and Gordon T. Stewart, is the first of its kind to be published; it demonstrates how much a methadone maintenance program (or any other program) can learn from studying its own failures.

The study was undertaken because of what seemed like an excessively high failure rate; of 264 patients admitted to the program between November 1968 and February 4, 1970, 95 (35 percent) had dropped out by the end of the fifteen-month period. On analysis, however, it appeared that the failures were fewer than appeared.

Seventeen of the 95 dropouts, for example, had transferred to other methadone maintenance programs and could hardly be deemed failures. Seven other dropouts later returned to the program. One dropout was in a hospital with tuberculosis, one was a soldier in Vietnam, and three were dead. Five claimed that they left the program because they wanted to live drug-free, and three or four of these appeared to be making it; they "seem to have dropped out of the drug scene, are working, and are not associating with present or former clinic members." Several left soon after starting on methadone--- one after being on the program only two days. One, married and with nine children, seemed to be doing very well (he had held the same job for seven years), even though he was back on heroin. Thus, the actual failure rate was closer to 20 percent.

Fifty-eight dropouts were interviewed and asked, "Why did you drop out of the program?"
One reason often given was that the patients didn't like a particular straw boss"--- a fellow-patient "who was given authority by the clinic operators to keep the peace, enforce rules, and maintain order, to see that no weapons, narcotics, or contraband drugs were brought, consumed or sold on the premises, and to perform a variety of other chores. This man had a reputation of being dangerous and powerful but also of being a stoolie for the police and of jacking or stealing from addicts themselves. He is therefore both feared and disliked." Complaints against him fell into five categories: "(1) ratting to the program directors, resulting in disciplinary action; (2) ratting to the police; (3) access to and illicit sale of methadone; (4) threats of bodily harm to extort loans; and (5) general abuse of authority." One of the patients who dropped out explained: "He is a rat for the police. He borrows money and then threatens you if you ask for it. He had access to the methadone and sold it--- I even bought some. I would like to go back on that program but not until he leaves."

In all, 17 patients cited this man as at least one of their reasons for dropping out. The remarkable finding of the study, however, was the fact that so many patients stayed in the program despite the presence of such a character in a position of authority--- a tribute, surely, to the holding power of methadone.

The situation in this clinic might be considered an argument against placing patients in positions of authority in a methadone maintenance program. Quite the reverse, however, is actually the case. If patients had been accepted as part of the therapeutic team at the beginning of this program, the administration would have been warned in advance against placing such a man in a position of power--- or his abuses would have come to light far earlier. It was absence of patient cooperation in the clinic's management (with the exception of this one patient) which made such abuses possible.

Twenty-eight percent of the dropouts interviewed also cited as a reason their "difficulty in paying for methadone." This reason seems highly implausible on the face of it. The clinic charged only $10 a week for methadone. Every addict on the list had been spending far more than that often ten or twenty times that much--- for black-market heroin. The New Orleans report, however, indicates that there is a difference:

... Whereas they feel little compunction about stealing to support a heroin habit, heroin addicts do not want to steal to support the methadone habit. One of the dropouts, now in prison, explained it this way: "It is one thing to get money hustling for smack [heroin] but when you are on methadone you want to stop hustling and get a job . . . then the money is hard to get."

One possible solution, of course, is to discontinue clinic fees altogether. Another is to waive the fee for unemployed patients and other hardship cases.

"Difficulty in seeing a doctor" was complained of by 17 percent of the dropouts interviewed. "Uncertain doctors' hours, long waits, 'come back next week,' and other delays finally led several to abandon the program." Fourteen percent complained of "arrogance, lack of understanding, 'police type' attitude, and airs of superiority." One
In the light of such findings, even a 35 percent dropout rate seems readily understandable, and the reforms required to lower the dropout rate are clearly visible. Consumers Union strongly recommends that every methadone maintenance clinic—such as those with dropout rates higher than that of the Dole-Nyswander program—conduct such followup studies periodically to find out what is wrong.

A cause of relatively high failure rates in some areas is antimethadone propaganda aimed at methadone patients, designed to turn them against the program. Some of this propaganda is well-meaning; it comes from people who believe that addiction is curable and that a patient on methadone is still an addict. "Be a man and kick the methadone" is the message. Some of the propaganda, however, is less well motivated. Patients are told that methadone gets into the bones and rots them, or destroys sexual function, or harms users in other ways. Black methadone patients, as noted above, are told that methadone is "white man's medicine," part of a genocide conspiracy. There is reason to believe that heroin traffickers, among others, are active in spreading such antimethadone rumors, for an obvious reason: every patient on methadone means one less customer for illicit heroin.

In several cities visited in the course of research for this Consumers Union Report, the chief source of antimethadone propaganda was not the heroin traffickers but the staffs of therapeutic communities and other treatment facilities, usually ex-addicts themselves. They are unquestionably well-intentioned, and they believe quite fervently that methadone is part of the "opiate evil." Their sincerity earns them a strong influence on community sentiment. Listeners feel an instinctive sympathy for these ex-addicts who have "made it the hard way." Yet the policy they recommend is disastrous, for as we have shown, the therapeutic communities can at best salvage a few—while methadone is already salvaging tens of thousands. As a methadone program becomes well established in a community, and as the success of its patients becomes visible in the neighborhood, the effectiveness of antimethadone propaganda campaigns tends to taper off.

Another cause of relatively high failure rates is lack of skill in helping addicts through the difficult first weeks or months on methadone. If the early doses are too small, the addict experiences discomfort and thinks he has been lied to about methadone. If escalation is too rapid, side effects occur—including, as noted above, a temporary diminution of sexual potency. Patients experiencing either of these kinds of effects need not only dosage adjustment but also guidance and counsel from informants they trust—preferably ex-addicts who have "made it" on methadone and who can honestly assure them that most of the unwanted effects are temporary.

The quality of life of the addict while still on heroin may also be a factor affecting failure rates. The chief advantage of methadone, after all, is that it "gets the monkey off the back" of the addict. Among addicts who are, leading reasonably satisfactory lives on morphine or heroin (as in Dr. O'Donnell's Kentucky study), the relative advantages of methadone may be fewer and the program therefore less successful. Recently addicted
adolescents in particular may not appreciate the full advantages of methadone maintenance because they have not yet experienced the full miseries of street addiction.

Finally, it should be noted that each program in effect sets its own failure rate. Few patients give up methadone maintenance voluntarily; most patients who leave are involuntarily terminated for repeated violation of the program's rules. An excessively punitive discharge policy, especially for addicts new to the program, is thus inevitably reflected in a high failure rate.

This is hardly an exhaustive catalogue of reasons why some methadone maintenance programs do less well than others. In each case of less than optimal success rates, a local study is called for to identify the reasons and correct them. In general, however, the dice are loaded in favor of a high success rate for every methadone maintenance program, for each program is in competition with black-market heroin and its attendant prices and hazards. Any methadone maintenance program that cannot win customers away from that competition must be doing something terribly wrong.

**Footnotes**  
**Chapter 18**


6. Personal communication.


8. Personal communication.


10. Ibid.

11. Ibid., p. 95.

12. Ibid.


20. Ibid., p. 93.

21. Ibid., pp. 77-78.

22. Ibid., p. 79.

23. Ibid.


25. Ibid., p. 38.

26. Ibid.

27. Ibid.


32. Ibid., p. 275.